MOSQUITOBORNE ENCEPHALITIS CASE INVESTIGATION - Page 1 of 4

Indiana State Department of Health
State Form 51382 (R/4-04)

DIRECTIONS - PLEASE READ BEFORE YOU BEGIN:

1. Print firmly and neatly.
2. Only use pens with blue or black ink.
3. Fill in circles like this: ● Not like this: ⊗ ✓ Mark mistakes like this: ✓
4. Print capital letters only and numbers completely inside boxes. A 2 C 3
5. Please complete all items on form.
6. **Date format: MM/DD/YY**

Section 1. Demographic Information

Last Name

First Name **MI** **Phone Number** - -

Number & Street Address

City **State** **ZIP Code** -

County **Date of Birth** / / **Age**

Race:
- ○ Asian
- ○ Black or African American
- ○ American Indian or Alaska Native
- ○ Native Hawaiian or Other Pacific Islander
- ○ White
- ○ Other/Multiracial
- ○ Unknown

Ethnicity:
○ Hispanic or Latino ○ Not Hispanic or Latino ○ Unknown

Sex:
○ Male ○ Female ○ Unknown

Is Age in day/mo/yr?
- ○ Days
- ○ Months
- ○ Years

Occupation **Phone of Employer/School/Day Care** - -

Name of ○ Employer ○ School ○ Day Care

Address of Employer/School/Day Care

City **State** **ZIP Code** -

Section 2. Clinical Information

Symptoms (check all that apply):
- ○ Fever . *(degrees)*
- ○ Headache
- ○ Dizziness
- ○ Myalgia
- ○ Fatigue
- ○ Paralysis
- ○ Rash
- ○ Neck Stiffness
- ○ Stupor
- ○ Disorientation
- ○ Tremors
- ○ Muscle Weakness
- ○ Convulsions
- ○ Other, specify:

Date of Onset / /

Duration of Symptoms in Days

Date First Positive Specimen Collected / /

Acute Flaccid Paralysis?
- ○ Yes
- ○ No

Method of Testing Used:

○ Culture
Specimen
Results: ○ Positive ○ Negative

○ PCR
Specimen
Results: ○ Positive ○ Negative

○ CSF

○ Serology
See page 2.

THIS FORM CONTAINS CONFIDENTIAL INFORMATION PER 410 IAC 1-2.3

Reset

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Section 2. Clinical Information (continued)

1. IgM Testing

__/__/__
Acute Specimen Taken

Acute Value

__/__/__
Convalescent Specimen Taken

Convalescent Value

Results:
- ○ Significant Rise in IgM
- ○ No Significant Rise in IgM
- ○ Indeterminate
- ○ Pending
- ○ Not Done
- ○ Unknown

2. IgG Testing

__/__/__
Acute Specimen Taken

Acute Value

__/__/__
Convalescent Specimen Taken

Convalescent Value

Results:
- ○ Significant Rise in IgG
- ○ No Significant Rise in IgG
- ○ Indeterminate
- ○ Pending
- ○ Not Done
- ○ Unknown

Physician/Hospital that Collected Specimen

Physician/Hospital Address

City **State** **ZIP Code** -

__-__-__
Physician/Hospital Phone

Was the patient hospitalized before or during infection?

○ Yes ○ No

If Yes, admission date: __/__/__

Discharge date: __/__/__

Hospital:

Did patient die?

○ Yes ○ No

Diagnosis:
- ○ Encephalitis
- ○ Uncomplicated fever
- ○ Other clinical
- ○ Meningitis
- ○ Asymptomatic infection
- ○ Unknown

1. Did patient receive blood or blood product within previous 30 days? ○ Yes ○ No

2. Did patient donate blood or blood product within previous 30 days? ○ Yes ○ No

3. Is the patient a Presumptive Viremic donor? ○ Yes ○ No __/__/__ **If Yes, donation date**

4. Was patient an organ recipient or donor within previous 30 days? ○ Yes ○ No

5. Is patient pregnant? ○ Yes ○ No

6. Was the patient breast-feeding at the time of the illness? ○ Yes ○ No

Section 3. Risk Factors

Patient's home setting:
○ Urban ○ Suburban ○ Rural

Is the patient's home located adjacent to (check all that apply):
○ Wetlands ○ Woods ○ Marsh/Bog ○ Dumps
○ Streams ○ Ponds ○ Sewage/Septic Effluent ○ Other Area(s) of Standing Water

Are any of the following water containers located outside of the home or area (check all that apply)?
○ Birdbaths ○ Fountains ○ Used Tires
○ Garden Ponds ○ Pools

○ Other Containers, specify: _____

Does home have working screens for windows and doors?
○ Yes ○ No

During the two weeks prior to symptoms, did the patient:

Engage in outdoor activities at home?
○ Yes ○ No

_____
If Yes, describe

__ / __ / __
Date

Engage in the following activities (check all that apply)?
○ Camping ○ Hiking ○ Fishing ○ Picnicking

_____
If so, where

__ / __ / __
Date

Travel to recreational areas within county of residence?
○ Yes ○ No

_____
If Yes, where

__ / __ / __
Date:

Travel outside of county of residence but within Indiana?
○ Yes ○ No

_____
If Yes, where

__ / __ / __
Date

Travel outside of Indiana?
○ Yes ○ No

_____
If Yes, where

__ / __ / __
Date

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Section 3. Risk Factors (Continued)

Stay overnight away from home?

○ Yes ○ No

If Yes, where

Date

During the two weeks prior to symptoms, did the patient:

Sustain any known mosquito bites?

○ Yes ○ No

If Yes, date:

Section 4. Diagnosis

Diagnosis:

Eastern Equine Encephalitis	○ Suspect	○ Probable	○ Confirmed
St. Louis Encephalitis	○ Suspect	○ Probable	○ Confirmed
La Crosse Encephalitis	○ Suspect	○ Probable	○ Confirmed
West Nile Encephalitis	○ Suspect	○ Probable	○ Confirmed
Other	○ Suspect	○ Probable	○ Confirmed

If Other, specify

Section 5. Comments/Follow-up

Comments:

Investigator Name

Agency

Phone Number **Date**